Please attach copies of latest culture reports with susceptibilities if available

Name/Addres	s of Sending Facility		Sending Unit		Phone #
	-				
Sending Facility Contacts	Name		Phone		Fax#
Case Manager/Admin/SW					
Infection Prevention					
Attending Physician:		Infectious Disease Physician:			
Is the patient currently in transmission	n based precautions (TBP)? ☐ NO ☐	YES			
Type of TBP (check all that apply)	□ Contact	□ Drople	et □ Airborne □ C	Other:	
Current or previous diagnosis of Sep			Approx date:/_		
Does patient currently have an infection, colonization or history of positive culture of a multidrug-resistant organism (MDRO) or other organism of epidemiological significance?			on treatment	Colonization or history Check if YES	Source
Methicillin-resistant Staphylococcus	aureus (MRSA)				
Vancomycin-intermediate Staphylococcus aureus (VISA) and/or Vancomycin-resistant Staphylococcus aureus (VRSA) Infections					
Vancomycin-resistant Enterococcus (VRE)					
Clostridium difficile (C Diff)					
Acinetobacter, multidrug-resistant					
E coli, Klebsiella, Proteus etc. w/Extended Spectrum B-Lactamase (ESBL/MDRO)					
Carbapenemase resistant Enterobacteriaceae (CRE) or Pseudomonas					
Other:					
Does the patient currently have	ve any of the following?				
☐ Has the patient ever been diagnosed with active or latent TB? ☐ NO ☐ YES					
☐ Cough or requires suctioning ☐ Central line/PICC/Port a Cath (Approx date inserted/) Indication:					
☐ Diarrhea ☐ Hemodialysis catheter/Shunt (Approx. date inserted/)					
□ Vomiting □ Urinary catheter (Approx date inserted /) Indication:					
□ Incontinent of urine or stool □ Suprapubic catheter					
□ Drainage (source) □ Percutaneous gastrostomy tube					
☐ Tracheostomy ☐ Open wounds or wounds requiring dressing change					
□ Surgery in the last 90 days Type(Approx. date//) Condition of Incision:					
• •	days (Required for ECF bed only)	ж. ч ато			····
Is the patient currently on anti) UVE	9		
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Antimicrobial agent and dose	Treatment for:		Start Date	Ai	ticipated Stop Date
Influenza Vaccine Month/Year administered:/					
Pneumococcal Vaccine Month/	Year administered:/				
Name and phone number of individual at receiving facility			Person completing form at time of transfer		
Due to the critical	nature of patient, we are unable to obtain the	ne comple	te infectious disease red	cord at time of	transfer.
	nation Management at XXX-XXX-XXXX				